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In The

Supreme Court of the United States

NORMA McCORVEY,
FORMERLY KNOWN AS JANE ROE,

Petitioner,

v.

BILL HILL,
Dallas County District Attorney,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF OF FETAL PAIN AMICI CURIAE IN SUPPORT OF PETITIONER

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STATEMENT OF INTEREST OF THE AMICI CURIAE

Amici Curiae have a substantial interest in the disposition of this case. The author and editor, have a substantial interest in this case and are requesting this Honorable Court reconsider *Roe v. Wade* in the interest of women. The undersigned make this request because of factual and legal changes in the scientific certainty now concerning the viability and humanity of the fetus, the evidence of excruciating fetal pain, and the resultant psychological damage to women who, without informed consent, terminate the lives of their fetuses. This amici curiae brief is submitted in support of the Petitioner. By letters filed with the Clerk of the Court, Petitioner and Respondent have consented to the filing of this brief.[1]

The abstract is written and edited by the Suzanne Besser, BS and Dr. Lucinda Harman, RN, MA, Ph.D., and attached in its entirety as Appendix A.

Suzanne Besser has spent the last 20 years researching, writing and speaking on topics concerning prenatal children, their parents, families, and neighbors. Her work focuses on depolarizing methods, thorough research, and close scrutiny of medical and scientific sources for bias and validity. She does not consider her approach "pro life" she considers it "pro information." She has presented to universities, physicians, nurses, scientists, youths, and children across the United States. Her message focuses on the miracle of human life, the unique sensory developmental milestones through which every person passes during the prenatal period of their lives. She also teaches about the fallacies of the sexual revolution and how one can avoid the hardships they create. In 2003, Suzanne was

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[1] The parties have consented to the filing of this brief.

Counsel for a party did not author this brief in whole or in part. No person or entity, other than the Amicus Curiae, its members, or its counsel made a monetary contribution to the preparation and submission of this brief. Counsel of record is applying to the Alliance Defense Fund for reimbursement for expenses printing and copying this brief.

invited to offer comment and recommendation to the State of Texas House Bill 15 "A Woman's Right to Know" workgroup. Two of her suggestions were incorporated into the resulting state mandated document. That same year Suzanne founded Miracle You Ministries as an educational and consulting organization focusing on issues concerning prenatal life and sexual and reproductive integrity. On January 23, 2005 Miracle You Ministries led the Sanctity of Human Life Fair at First Baptist Church in Belton, Texas. Miracle You Ministries is an affiliate of a not-for-profit, evangelical Christian missions organization, Hope for the Hungry. This affiliation affords Miracle You Ministries membership in the Evangelical Financial Accountability Council. Accountability is a theme of Suzanne's work and the ministry she directs.

Ms. Besser has her Bachelors in General Studies and secondary teaching certification from the University of Mary Hardin-Baylor. She has taught middle school learners language arts, speech, and drama and university students' public speaking. Her master's studies are in counseling. Suzanne began researching, writing and speaking on issues involving prenatal children in 1983. She has spoken to physicians and other professional organizations on these issues across the United States and introduced the issue of the prenatal child's ability to experience sensation including pain, to the State of Texas House Bill 15 "A Woman's Right to Know" brochure workgroup. Her work prompted the group's inclusion of two statements, concerning sensation and pain, in their brochure. Dr. Lucinda Harman has her Masters and Ph.D., in Neuro Science from the University of Louisville. She is a registered nurse, has practiced neonatal intensive care nursing, and done research in neonatology. Dr. Harman edited Suzanne Besser's paper on the prenatal child's ability to experience sensation and pain in the fall of 2003.

SUMMARY OF THE ARGUMENT

Casey threw out the "rigid trimester" approach of *Roe,* but the progeny of the two have failed to give sufficient

guidance to state legislatures in that statutes continue to be returned to this court because of the vagueness of that term. *Stenberg* seems to have embraced the trimester formulation again with gestation in a Dilation and Evacuation abortion causing fetal arms and legs being ripped from unborn bodies in the birth canal. It does not take a rocket scientist to envision the horrific pain of a baby ready to be born who is terminated in this manner, but now objective medical evidence documents the fetal pain. Amicus, if this case is granted certiorari, will present evidence of fetal pain in the district court, with fetus as young as 7 weeks gestation responding to stimuli; evidence that was unavailable to the court in 1973. And, neonatal medical evidence that amici will bring before the district court will show that fetus as young as 22 weeks have survived. The ability of the fetus to survive outside the womb was the standard under *Roe,* and *Planned Parenthood of Central Missouri v. Danforth* (No. 74-1151), 428 U.S. 52 (1976), and *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992).

In sharp contrast the states have developed all other laws concerning children to require the standard of the best interests of the child, with mandatory appointment of guardians ad litem when the child's interests may be at risk. In every jurisdiction all other state laws concerning children are completely inconsistent with *Roe* which decided the very life of the fetus without a legal representative for the unborn child. This court must grant certiorari in order to consider the factual and legal changes that make *Roe* unconscionable and give guidance to legislature and the lower courts.

Judge Edith H. Jones noted in her concurring opinion below that "[t]he perverse result of the Court's having determined through constitutional adjudication this fundamental social policy, which affects over a million women and unborn babies each year, is that the facts no longer matter." *McCorvey v. Hill*, No. 03-10711, slip op. at 5 (5th Cir. Sept. 14, 2004).

ARGUMENT

I. THE FIFTH CIRCUIT WRONGLY DECIDED THAT ISSUES RAISED IN *MCCORVEY* WERE MOOT BECAUSE CHANGED FACTUAL CIRCUMSTANCES AND THIS COURT'S RECENT CONSTITUTIONAL DECISIONS HAVE UNDERMINED THE LEGAL FOUNDATIONS OF *ROE*.

A. LATER CASES HAVE UNDERMINED *ROE V. WADE*, 410 U.S. 113, 165, 166 (1973)

When considering a Rule 60(b) motion based on a change in law, the movant's "ability to satisfy the prerequisites of Rule 60(b)(5) hinges on whether [the Court's later] cases have so undermined [the challenged decision] that it is no longer good law." *Agostini v. Felton*, 521 U.S. 203, 217-18 (1997). Specifically, the Court must examine whether the "more recent cases have undermined the assumptions upon with [the challenged decision] relied." *Id.* at 222.

This case presents the Court with a one-of-a-kind opportunity to reconsider *Roe v. Wade*, 410 U.S. 113, 165, 166 (1973) in light of intervening changes in law and fact since 1973. *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992) at 876 recognized a state interest throughout pregnancy and changed the "rigid trimester" formulation for a standard of viability. *Planned Parenthood of Central MO v. Danforth*, 428 U.S. 52 (1976) at 63 upheld the viability standard and defined it as the age at which a fetus could live outside the womb. *Stenberg v. Carhart* (99-830) 530 U.S. 914 (2000) at 915 allows a 24 week old unborn fetus, a viable infant by any current medical evidence (see Amicus' Argument II) to be destroyed in a partial birth abortion without overruling the viability standard. *Casey* and *Danforth's* recommitment to viability and *Stenberg's* ignoring that standard creates a conflict that is confusing to lower courts and state legislatures. This conflict undermines the challenged decision and negates the Fifth Circuit's decision based on "mootness."

B. THE FACTUAL AND LEGAL LANDSCAPE HAS CHANGED SINCE 1973

The threshold issue to be decided by a Court in evaluating petitioner's motion for relief from judgment under Rule 60(b) is "whether the factual or legal landscape has changed since . . . [the prior ruling of the Court]." *Agostini*, 521 U.S. at 216. Although the court of appeals concluded that Petitioner's motion was timely, it did not reach the merits of the motion because it concluded that the case was moot. *McCorvey*, slip op. at 5. Amicus argues against mootness regarding the ripe issues examining fetal pain and viability given the current confusion after *Stenberg* departed from the viability standard articulated in *Roe*, *Casey*; and *Danforth*. The advances in evidence of fetal pain and viability, unknown at the time of *Roe* and its progeny, and its need to be re-examined under application of *Agostini*; and the cases waiting in the wings on Fetal Pain, Partial Birth Abortion and lawsuits by Abortion Survivors with horrific injuries; and the need for guidance for state legislatures and district courts with the apparent vacuum concerning viability being recognized as originally articulated but apparently, without overruling previous cases, departed from in *Stenberg*.

C. AMICUS FOCUSES ON SUBSTANTIVE ISSUES

The instant brief is focused on the substantive issues ignored by the lower courts when they decided this case on procedural grounds which will be presented to this Court once certiorari is granted. Amicus restates the issues raised on mootness, constitutional federalism and the rational basis standard that have been raised in briefs by other amici, and incorporates them by reference, while specifically focusing on Amicus' concern that the Fifth Circuit decided an important question of federal law that has not been, but should be settled by the Supreme Court, addressing the new factual and legal issues. This case presents substantial issues of national importance. First, as expressed *supra,* whether a vagueness in application of standards of viability as discussed in *Stenberg* needs further clarification to give guidance to state legislatures

and District Courts, given the seeming contradiction with *Casey,* and *Danforth*'s standard of viability. Second, an examination of the latest factual evidence to determine whether the new factual evidence of fetal viability/ humanity and fetal pain has undermined the factual foundations of *Roe*, rendering prospective application of *Roe* unjust. Third, and fourth, whether the Court's decision in *Washington v. Glucksberg*, 521 U.S. 702 (1997), *Vacco, Attorney General of New York v. Quill*, 521 U.S. 793 (1997), *Cruzan by Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990) and other developments in constitutional federalism, the new standard of the best interest of the child in all cases involving children in all 50 states, and the mandatory appointment of Guardians ad Litem to represent the interests of the child where abuse is alleged, have undermined the legal foundations of *Roe* rendering prospective application of the judgment unjust. The Court should grant the petition for a writ of certiorari to consider these substantial issues of national importance. This evidence, however, amply justifies relief under Rule 60(b) and the Court should grant the writ of certiorari.

II. THE CURRENT MEDICAL AND SCIENTIFIC UNDERSTANDING OF THE VIABILITY OF THE FETUS AND FETAL PAIN HAS UNDERMINED THE FACTUAL FOUNDATION OF *ROE*.

The following argument incorporates research on the scientific changes in medical knowledge in regard to fetal viability umanity and fetal pain since the decisions of *Roe* and *Ca..ey*. The abstract is written and edited by Suzanne Besser, BS and Dr. Lucinda Harman, RN, MA, Ph.D., and attached in its entirety as Appendix A.

A. *ROE, CASEY, DANFORTH, STENBERG* AND VIABILITY

The unborn child usually lives inside its mother's womb forty weeks. These are called the weeks of gestation. In the past, this gestational period was compared to the process one might find in baking bread. Up until the time that abortion laws became stricter, in the mid 1800s, little

was widely known about the true nature of prenatal development. People thought maybe unborn children went through similar processes as in baking bread. Thus the old adage, "She has a bun in the oven." However, humans do not develop through the combination of ingredients, fermentation, and the change that occurs when heat is applied. Advances in medical, scientific, and technical abilities have changed understanding of whom and what unborn children are. We now know that the time humans spend inside their mother's womb is not some type of changing from one thing into something else through chemical reactions, but rather normal growth and development that begins upon the complete union of the egg and the sperm. Medical research since 1973 documents understanding of fetal pain of the unborn child. *Besser* A2

Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833 (1992) overturned the trimester formulation of *Roe v. Wade*, 410 U.S. 113 (1973) recognizing that the fetus was at least potential human life, even from conception, *Casey* noted, "the trimester framework, however, does not fulfill *Roe*'s own promise that the State has an interest in protecting fetal life or potential life before viability. *Roe* began the contradiction by using the trimester framework to forbid any regulation of abortion designed to advance that interest before viability." *Casey*, at 876. "*Roe* and subsequent cases treat all governmental attempts to influence a woman's decision on behalf of the potential life within her as unwarranted. This treatment is, in our judgment, incompatible with the recognition that there is a substantial state interest in potential life *throughout pregnancy*" (emphasis added). *Casey, Id.*

Far from being moot, the issues *McCorvey* will bring before the district court, of fetal pain and viability, are on the cutting edge. In the *Stenberg v. Carhart*, 530 U.S. 914 (2000) decision, the Court appears to ignore *Casey's* determination that the standard was viability (defined by *Planned Parenthood of Central MO v. Danforth*, 428 U.S. 52, 63 (1976) as when a fetus could survive outside the womb). *Stenberg* at 915 authorizes a D & E abortion at 24 weeks, thus authorizing the ripping off of little arms and

legs of a 24 week old unborn child – a viable infant by today's standards of viability, capable of feeling great pain as today's neonatal medical and sentience evidence proves. *Stenberg* ignores the viability standard of *Danforth* and *Casey*, making the issues of the instant case ripe.

The undisputed current medical evidence has changed the factual considerations used under *Roe*. No longer can the court in its wildest imagination return to the comfortable position that the fetus after conception was ever some nonhuman cellular blob. The medical certainty that the fetus is from conception fully human, with all the potential to develop into everything it will ever be, mandates a return by cert to consider the best interests of the fetus using the changed factual evidence now available and applying the same standards developed to protect children, and with a legal representative, a Guardian ad Litem, appointed to speak for the unborn child's rights.

The following are recognized authorities on the humanity/viability that have defined the unborn child since *Roe* was decided in 1973.

The gestational age of viability of the very preterm neonate has steadily progressed downward from 28 weeks in 1973 to 23 weeks in 1998 because of the vast improvement in medical assistance available for the very early preterm neonate. The term "micro-premie" has been coined to describe these 23 to 28 week gestation preterm neonates (Wright, 1998). In a longitudinal study of infants born between May 1988 and September 1991 in one hospital, it was found that 15% of infants born at 23 weeks, 56% born at 24 weeks, and 79% born at 25 weeks survived for at least six months (Allen, et al., 1993). By 1994, infants at 23 to 24 weeks gestation had fair chances of survival and infants at 25 weeks and greater had good chances. In Japan, the Japanese Eugenics Act was amended to place the age at 22 weeks. In 1997 they reported 18% survival rates of micro-premies at 22-23 weeks (Oishi, et al., 1997). At any gestational age, these preterm infants should be provided compassionate care

and pain control (Fetus and Newborn Committee, et al., 1994).

"Human development begins after the union of male and female gametes or germ cells during a process known as fertilization (conception). "Fertilization is a sequence of events that begins with the contact of a sperm (spermatozoon) with a secondary oocyte (ovum) and ends with the fusion of their pronuclei (the haploid nuclei of the sperm and ovum) and the mingling of their chromosomes to form a new cell. This fertilized ovum, known as a zygote, is a large diploid cell that is the beginning, or primordium, of a human being." [Moore, Keith L. Essentials of Human Embryology. Toronto: B.C. Decker Inc., 1988, p. 2]

B. FETAL PAIN AND LAW CONCERNING THE UNBORN

Ms. Besser and Dr. Harmon address the issue of fetal pain as follows:

> 1) Fetal development with respect to pain; 2) Increased sensitivity to pain of preterm infants and unborn children compared to their term counterparts; 3) Effects of maternally administered anesthesia on the fetus with respect to pain management; 4) The age of viability of the unborn child with the advent of new neonatal research and clinical advances; 5) Statistics of abortion and late term abortion; 6) The methodology of abortion throughout the gestational period; 7) Reasons cited for late term abortion; and 8) Anesthesia and analgesia for the unborn child during abortion. A2
>
> The literature with respect to the development of the nervous system in the human unborn child addresses the topic from the perspective of the very preterm neonate as well as the intrauterine studies. According to Dr. Jean Wright's testimony to the U.S. House (1996) and Senate (1998), studies provide insight into the development of the human unborn child in a variety of directions. First, clear indication that the anatomical and physiological (structural and functional) processes that mediate nociception (pain and noxious stimuli) are present in very preterm neonates.

Furthermore, the density of nociceptive nerve endings in the late fetus and newborn infant are at least as dense as in the adult human (Wright, 1996). Sensory perception (response to sensory stimulation) occurs in the unborn child by the 7th week of gestation around the mouth (Richeimer, 2000) and spreads to the entire skin and mucous surfaces by 20 weeks gestation (Wright, 1996). Experiments have demonstrated that this process of sensitivity progresses in the unborn child in the following manner. At just before 8 weeks gestation the unborn child will manifest a set of protective movements to avoid a mere hair stroke on the cheek. This sensitivity extends to the genital area at 10 weeks, the palms of the hands at 11 weeks and the soles of the feet by 12 weeks. By 17 weeks, the abdomen and buttocks are sensitive to this type of stimulation as well as to heat, cold, pressure and pain (Chamberlain, 2003). A2

Additional investigations into the development of the unborn child demonstrate purposeful movement and exploration by the fetus at 10 weeks gestation (Tajani and Ianiruberto, 1990). By 14 weeks, the unborn child demonstrates a complete repertoire of movement including spontaneous, provoked and interactive types therein exploring itself and its environment (deVries, Visser, and Prechtl, 1985). The structures for taste develop at about 14 weeks gestation and the nose with its sensory receptors develops between 11 and 15 weeks. New research indicates that the chemicals that cross the placenta barrier to mix in the amniotic fluid permit the unborn child a range of tastes and smells. This stimulates development of the neurological circuits. Schaal, Orguer, and Rogan (1995) cite evidence for direct and indirect learning of odors including dietary products ingested by the mother. This learning prepares the newborn to respond to various odors with no extrauterine experience for those odors. A2-3

Reactive listening begins at 16 weeks gestation – fully 8 weeks before the external ear has completely developed (Shahidullah and Hepper, 1992). Currently,

it is not possible to assess vision in utero but premature babies from 28 to 34 weeks gestation are able to begin to focus and soon track visual stimuli in both vertical and horizontal directions (Chamberlain, 2003). A3 With this evidence of the development of the neurological circuits for the unborn child in terms of touch (somatosensory), movement (vestibular), pain (nociception), smell (olfactory), taste (gustatory), sound (auditory) and possibly sight (visual), it becomes evident that the unborn child is a sensing being beginning at 7 weeks gestation and progressing to more integrated sensory experiences through 28 weeks gestation. At 20 weeks gestation, twins in utero have no trouble locating each other and touching each other's faces and holding hands (Chamberlain, 2003). A3

Touch develops first and includes pain sensation. The fetus, by the middle week of the gestational period feels touch and pain all over its body. The lack of myelination of the nociceptive neurological tracts does not negate the perception of pain. In fact, the nociceptive impulses in adults can be carried in unmyelinated or thinly myelinated fibers. Additionally, the nerve tracts associated with nociception in the spinal cord (reflex pain fibers) and brain stem are completely myelinated up to the thalamus by 30 weeks gestation. The thalamus is the brain organ that integrates all sensory stimulation except smell and sends signals to the various parts of the cortex for processing. A3

The unborn child's neocortex begins development at 8 weeks gestation and has a full complement of neurons by 20 weeks. The connecting components of cortical neurons (dendrites) proliferate and connections with the thalamus and other portions of the cortex occur. These connections occur between 20 and 24 weeks gestation (Anand, et al., 1987). With this integration in mind, it is not surprising that EEG (brain wave) patterns in preterm babies of less than 28 weeks gestation are present with both visual and auditory evoked potentials demonstrating cortical components, and somatosensory (touch, pain, heat and

cold) evoked potentials were measured at 26 weeks gestation (Wright, 1998). This means that these babies are processing touch, pain, temperature, sound and light by 26 to 28 weeks of gestation. Well defined periods of sleep and wakefulness are present in utero from 28 weeks forward (Wright, 1996). A3 Ultrasonic recordings of fetal responses to needle punctures in utero and intrauterine blood sampling reveal that unborn children between 20 and 24 weeks gestation demonstrate hormonal responses to pain consistent with fetal perception of pain and were correlated with duration of the painful stimuli (Wright, 1998). Within ten minutes of inserting a needle into an unborn child's hepatic artery for transfusion, the unborn child shows a 590% rise in beta endorphin and a 183% rise in cortisol (Giannakoulopoulos, 1994). Beta endorphin is a biochemical produced in response to pain and cortisol is a biochemical produced in response to stress. By sixteen weeks gestation, unborn children have been recorded in reaction to the experience of amniocentesis by shrinking away from the needle or by attacking the barrel of the needle. Following this procedure, the unborn child's heart rate gyrates and different children react differently, some remaining motionless and some ceasing breathing motions for several days (Chamberlain, 2003). This is clear behavioral response to a painful stimulus. A3

Some scientists and psychologists, while recognizing all of the sensory and biochemical data, determine that while the unborn child may sense pain that it cannot appreciate pain because of a lack of cortical activity. Dr. Stuart Derbyshire (2003) and research fellow Ann Furedi conclude that fetal pain is a misnomer because the fetus does not have enough cortical integration to be able to interpret pain (Derbyshire & Furedi, 1996). Birnholz (1981) demonstrated that babies as early as 23 weeks gestation demonstrate rapid eye movement during sleep. Rapid eye movement is very highly correlated with dreaming. Dreaming, a cortical activity integrating experiences into the

various portions of the cortex, involves coherent movements of the face and extremities in synchrony with the dream itself and manifests itself with either pleasant or unpleasant facial expressions. Dreaming is neither reactive nor evoked but is endogenous and indicative of inner mental or emotional conditions (Chamberlain, 2003). Any new experience remains uninterpreted until it is experienced by the organism. This is true for the mature and the immature organism. Therefore, whether or not the unborn child can interpret the experience of pain, this child does experience it! A4

Increased sensitivity to pain of preterm infants and unborn children compared to their term counterparts:

Historically, it was thought that the preterm infant had less sensitivity to pain than did the term neonate or adult human. Studies now reveal this to be false. Five key indicators have been used to demonstrate this pain perception. The first is the cutaneous flexor reflex. This is used to determine when the connection between the skin and the spinal cord are first made in the unborn child. This reflex has been shown to parallel pain perception in terms of threshold, peak intensity, and sensitivity to analgesics in adult humans. Thus, that the threshold is lower in the preterm neonate indicates that pain perception is more easily triggered than in the adult (Wright, 1996).

The second indicator is neurotransmitter development. This development in the dorsal horn of the spinal cord has early and abundant expression of those neurochemicals mediating pain. Furthermore, the preterm neonate demonstrates a greater sensitivity with less ability to inhibit pain perception because of underdeveloped pain control mechanisms in the spinal cord. Improved survivability and improved clinical outcomes have been demonstrated in research studies in neonatal intensive care units where micro-premies in one group received morphine analgesia and their like age counterparts did not receive pain control. The results of this study clearly indicate that the outcomes are greatly improved with the administration of pain

control medications. The neonates were from 24 to 32 weeks gestation (Anand, et al., 1999). A4

In accord with this study is the third key indicator. Researchers have demonstrated that the opioid centers in the fetal brain stem have very high density. It is thought that this mechanism protects the unborn child from overstimulation of the pain tracts prior to the development of other control mechanisms such as gate control (Wright, 1996). A4

Fetal surgery and neurochemicals studies, the forth indicator, have demonstrated that pain and surgical stress can be measured by the outpouring of pituitary, adrenal, and pancreatic hormones as well as by cardiovascular responses. This is in accord with pain research conducted on adults. These same researchers demonstrate that anesthesia for the unborn child may contribute to stress suppression and improved postoperative clinical outcome for this unborn child. Significantly, the addition of pain medication along with other forms of anesthesia was much more effective in suppressing stress response and improving postoperative outcomes (Wright, 1998). A4-5

Higher concentrations of the pain medications, the fifth indicator of pharmacokinetic studies, were needed to maintain surgical anesthesia in preterm neonates than in older patients. Changes in the expression of pain do occur, however, this illustrates a communication specificity, not a pain threshold change (Wright, 1996). A5

Effects of maternally administered anesthesia on the fetus with respect to pain management: Local anesthetics administered to the mother do not have any affect on the unborn child. Furthermore, intravenous sedation/anesthesia has minimal effects on the unborn child because the mother's liver clears much of the drug prior to the drug reaching the uterus and because the placental barrier screens chemicals entering into the fetal circulation. Because the fetus has more opioid receptors, it takes much higher doses to saturate the increased receptors and achieve a therapeutic response. The maternal receptors are saturated prior to

the drug reaching the unborn child, thus, the child is minimally affected (Wright, 1996).

The age of viability of the unborn child with the advent of new neonatal research and clinical advances:

> The gestational age of viability of the very preterm neonate has steadily progressed downward from 28 weeks in 1973 to 23 weeks in 1998 because of the vast improvement in medical assistance available for the very early preterm neonate. The term "micro-premie" has been coined to describe these 23 to 28 week gestation preterm neonates (Wright, 1998). In a longitudinal study of infants born between May 1988 and September 1991 in one hospital, it was found that 15% of infants born at 23 weeks, 56% born at 24 weeks, and 79% born at 25 weeks survived for at least six months (Allen, et al., 1993). By 1994, infants at 23 to 24 weeks gestation had fair chances of survival and infants at 25 weeks and greater had good chances. In Japan, the Japanese Eugenics Act was amended to place to age at 22 weeks. In 1997 they reported 18% survival rates of micro-premies at 22-23 weeks (Oishi, et al., 1997). At any gestational age, these preterm infants should be provided compassionate care and pain control (Fetus and Newborn Committee, et al., 1994). A5

Statistics of abortion and late term abortion for early abortions see Appendix:

> The lower court's decision to deny Petitioner's motion on grounds of mootness should not prevent this Court from considering her motion on the merits. The dismissal of this case on procedural grounds will only defer consideration of these issues to a later date. The time is ripe for this Court to squarely address the question of whether it is unjust for *Roe* to continue to have prospective application given the substantial changes in law and fact since 1973. Increasing sophistication in methods of scientific research have provided greater understanding and knowledge of the previously cloaked interuterine environment. Sonogram technology has improved, giving adults a clearer view into the womb. Fetal medicine improved, giving adults hands on experience with children in the

> womb. Premature birth rates have increased effecting greater numbers of person-to-person experiences with children who were gestationally younger and younger, dispelling previously held pre-human theories about prenatal life.

Neonatal medicine has improved dramatically, effecting high levels of care and compassion for all children, regardless of their gestational age at birth. This compassionate care pointed critical questions about the hundreds of thousands of unborn children who were dying during elective termination of pregnancy, or abortion, and who were the same gestational age or older than the prenatal patients who received, at the very minimum, pain management. None of the unborn children received pain management during abortion.

Elective terminations of pregnancies, abortions, are estimated 40 million in the last thirty years. An estimated 1.5% of these abortions have been performed at 21 weeks of gestation or older. Intrauterine surgeries provide strong evidence that pain management for unborn children is essential in successful procedures. Sensory perception has been demonstrated for all of the senses including the perception of pain. Response to touch, has been demonstrated in the unborn child as early as six weeks gestation. Therefore, if abortion is to be continued, anesthesia of the unborn child is the only mechanism available to avoid horrific pain.

Under *Roe v. Wade*, 410 U.S. 113 (1973), the fetus was not considered an unborn child until the third trimester and *Stenberg* seems to be following that trimester approach *Casey* overturned. The *Roe* court did not have the current medical and scientific evidence giving an understanding of fetal pain. This case presents the Court with a unique opportunity to consider whether it is just for *Roe v. Wade* to continue to have prospective application in light of the substantial changes in the factual assumptions and constitutional law underlying *Roe* that have taken place since 1973.

C. WOMEN ARE SUFFERING GREAT PSYCHOLOGICAL HARM

Women are suffering great psychological harm because they find out only later, after an abortion, of the unwitting pain they have inflicted upon their own children. (See Affidavits of Women, Petitioner's Brief.)

D. WOMEN ARE NOT MAKING INFORMED DECISIONS

Thirty years of experience with abortion has shown that women are not making informed decisions because they are not given information concerning the humanity of the fetus and scientific evidence of fetal pain. (See Affidavits of Women, Petitioner's Brief.)

E. PARTIAL BIRTH, FETAL PAIN, AND ABORTION SURVIVOR CASES

The Fifth Circuit decision on procedural grounds deprived *McCorvey* of the right for her motion to be heard on the merits, which will only defer consideration of these issues to a later date because Partial Birth, Fetal Pain, and Injury to Abortion Survivors cases will be coming before this Court.

III. *ROE V. WADE* IMPEDES, RATHER THAN INFORMS OR ADVANCES, THE NATURAL DEVELOPMENT OF FAMILY AND REPRODUCTIVE LAW, WHICH OTHERWISE HAS INCREASINGLY PROVIDED FOR ADVOCACY OF CHILDREN'S RIGHTS, WITH CONCURRENT ADVOCACY OF PARENTAL RIGHTS.*

A. A CHANGE IN THE LAW MAKES THE PROSPECTIVE USE OF *ROE V. WADE* IMPERMISSIBLY UNJUST

1) LEAD-IN TO 1973

Roe v. Wade was "set" in a very different legal milieu than exists today. Amidst different state legislatures'

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* This argument was developed by Marianna Trzeciak, Esq., an inactive member of the bars of NJ and PA.

consideration of changes in the Model *Penal* Code regarding abortion, circa 1967-1973, different courts were rendering decisions involving abortion in *criminal* cases. The crimes tended to involve domestic violence or proscribed behavior in the commission of an abortion.

For example, the California Supreme Court considered abortion law from the time of Coke, Blackstone and Hale when faced with a husband who had beaten his estranged wife, killing her unborn daughter (a viable fetus); and the legal issue was whether it would deny the husband due process of law to try him for the murder of a "human being," per the California criminal statutes. *Keeler v. Superior Court of Amador County*, 87 Cal. Rptr. 481, 2 Cal. 3d 619, 470 P. 2d 617 (1970).

Another example is of an abortionist who was tried for the crime of producing abortions not done for the preservation of the mother's life or health; and the legal issue was whether it would deny the abortionist due process of law to try him under a statute where the term "health" was argued (unsuccessfully) to be unconstitutionally vague. *United States v. Vuitch*, 402 U.S. 62 (1971).

Guardians ad litem for the unborn were not heard at trial. In fact, guardians ad litem at the time were more likely to appear in law involving inheritance of property, i.e., in courts of equity. See, e.g., *In re Hoppe*, 32 N.J. Super. 460 (Bergen County Ct., 1954); *In re Moran*, 116 N.J. Super. 238 (App. Div. 1971).

It is respectfully submitted that, in fact, abortion looks very different in the "eyes of equity": "Where One of Two Innocent Parties Must Suffer He Through Whose Agency the Loss Occurred Must Bear It. . . . " 2 Pomeroy section 363, p. 9. See also *Wenner v. Texas Lottery Com'n*, 123 F.3d 321, *suggestion for rehearing denied*, 132 F.3d 1458 (5th Cir.), *cert. den.*, 118 S.Ct. 1514, 140 L.Ed. 2d 667 (1997) [Texas].

2) AFTER JANUARY, 1973

The law of children's rights is substantially changed from what it was at the time of *Roe v. Wade*; therefore, it is unjust to permit its continuing effects.

B. BEST INTERESTS OF THE CHILDREN STANDARD

Throughout all jurisdictions, there is a standard known as the protection or consideration of the "best interests of the children." (Appendix B)

The "best interests of the child" standard does not govern parents' or guardians' exercise of custody; however, before a child's interests may be subordinated to another child's or even a parent's or guardian's, certain minimum requirements of child care must be met. *Reno v. Flores*, 113 S.Ct. 1439, 507 U.S. 292, 123 L.Ed. 2d 1, *on remand Flores by Galvez-Maldonado v. Meese*, 992 F.2d 243 (9th Cir. 1993).

Therefore, either in court ("best interests") or in the domestic sphere ("minimum requirements"), a child must receive advocacy or care.

C. GUARDIANS AD LITEM

The increase in reports of child abuse and neglect, divorce, juvenile offenses and other social factors since *Roe v. Wade* has created particular growth in the area of law of guardianship of children. See US Department of Health and Human Services, US Advisory Board on Child Abuse and Neglect, Child Abuse and Neglect: Critical First Steps in Response to a National Emergency, Washington, D.C., U.S. Government Printing Office, 1990. (Appendix B)

A guardian ad litem (GAL), also known as a court-appointed special advocate (CASA) [herein this brief subsumed under the acronym "GAL"] is usually a lawyer or a volunteer who participates as advocate for children in courtroom proceedings which include children. See, e.g., Victims of Child Abuse Act of 1990 (P.L. 101-647) and Indian Child Protection and Family Violence Act of 1990 (P.L. 101-630).

It was after *Roe v. Wade* that GALs rose to prominence and, in fact, organized for professional development. For example, in 1976, Superior Court Judge David Soukup of Seattle, Washington, obtained funding to recruit and train community volunteers to be GALs (there known as CASAs). "History of CASA," National

CASA Association website, *at* www.nationalcasa.org, Seattle, Washington, 2004 ("History of CASA"). Judge Soukup's work became the pilot program which was so successful that the work of volunteer GALs went nationwide in 1982, with the formation of the National Court Appointed Special Advocate Association. *Id.* The National CASA Association receives funds from the National Council of Juvenile and Family Court Judges, under the direction of the US Department of Justice, the Office of Juvenile Justice and Delinquency Prevention, as well as the US Department of Health and Human Services. *Id.* In 1990, the US Congress authorized expansion of CASA with the passage of the "Victims of Child Abuse Act of 1990," *supra*, so that a "court-appointed special advocate shall be available to every victim of child abuse or neglect in the United States that needs such an advocate." *Id.*

D. OTHER STATE LAWS

In virtually every context outside the abortion debate, the unborn are recognized as having a protectable right. See, Strahan, Legal Protection of the Unborn Child Outside the Context of Induced Abortion, 11 Association for Interdisciplinary Research in Values and Social Change (March/April 1997); Civil Rights – Fetus as a Person, 64 ALR Fed 886; Wasserstorm, Homicide Based on Killing of Unborn Child, 64 ALR5th 671; Wakefield, Unborn Child as Insured or Injured Person Within Meaning of Insurance Policy, 15 ALR4th 548.

Roe took factual situations which belonged and still belong in equity and examined them solely through the lens of the criminal law theory of substantive due process. *Roe* is increasingly archaic *vis-a-vis* the development of child and family protection laws and yet stands in the way of further (unimpeded) development of these laws. See concurring opinion of Judge Edith Jones, *McCorvey* slip op., *supra*.

CONCLUSION

For the foregoing reasons and those in the petition, the petition for a writ of certiorari should be granted.

Respectfully submitted,

PAMELA LAMBERT
Counsel for Amici Curiae

January 2005

APPENDIX A

ABSTRACT

Increasing sophistication in methods of scientific research provide greater understanding and knowledge of the previously cloaked intrauterine environment. Sonogram technology has improved, giving adults a clearer view into the womb. Fetal medicine improved, giving adults hands on experience with children in the womb. Premature birth rates increased effecting increased numbers of person-to-person experiences with children who were gestationally younger and younger dispelling previously held pre-human theories about prenatal life. Neonatal medicine improved dramatically, effecting high levels of care and compassion for all children, regardless of their gestational age at birth. This compassionate care pointed critical questions about the hundreds of thousands of unborn children who were dying during elective termination of pregnancy, or abortion, and who were the same gestational age or older than the prenatal patients who received, at the very minimum, pain management. None of the unborn children received any pain management during abortion. Elective terminations of pregnancies, abortions, are estimated 40 million in the last thirty years. An estimated 1.5% of these abortions have been performed at 21 weeks of gestation or older. Intrauterine surgeries provide strong evidence that pain management for unborn children is essential in successful procedures. Sensory perception has been demonstrated for all of the senses including the perception of pain. Response to touch, has been demonstrated in the unborn child as early as six weeks gestation. Therefore, if abortion is to be continued, anesthesia of the unborn child is the only mechanism available to avoid horrific pain.

The Prenatal Child: Issues on Sentience

Fetal anesthesia including analgesia:

Fetal surgery has been performed for four decades. The first decade resulted in about a 100% death rate. However, since that time and with drastic improvements in anesthesia, the survival rate for the unborn child undergoing surgery is very encouraging. In studies of this unborn patient, the use of analgesia along with anesthesia and paralytics, improved the clinical outcomes. (Cauldwell, Charles B., et.al., 2001). In a survey of British neuroscientists, 80 percent responded that they thought the fetus should receive pain control after 11 weeks gestation so that any error committed would be on the side of pain prevention. A British commission on fetal sentience concluded that the growing body of evidence indicates that the unborn child may experience suffering from around 11 weeks gestation. Dr. Robert White recommends that mothers receiving information about abortion also receive information about the pain and suffering the unanesthetized unborn child will experience. In this way, she will be better able to decide on a course of action (White, 1995).

Unborn children usually live inside their mother's wombs forty weeks. These are called the weeks of gestation. This sounds a little like the description of a process one might find on a home-made bread recipe. It might say, "Let the dough rise for two hours." In the past, no one could know what was really going on inside the womb. People thought maybe unborn children were going through a similar process as bread dough. This was logical since the mother's abdomen somewhat resembled bread dough as it grew

> in size and roundness. Advances in medical, scientific, and technical abilities have changed understanding of whom and what unborn children are. We now know that the time humans spend inside their mother's womb is not some type of changing from one thing into something else. We now know that this time is really just the early stages of normal growth and development that begins at conception and continues throughout the person's existence.
>
> Humans are described by different words. During the time a human lives inside their mother's womb they may be called, embryo or fetus.

(Merriam Webster, 2003)

1) Fetal development with respect to pain; 2) Increased sensitivity to pain of preterm infants and unborn children compared to their term counterparts; 3) Effects of maternally administered anesthesia on the fetus with respect to pain management; 4) The age of viability of the unborn child with the advent of new neonatal research and clinical advances; 5) Statistics of abortion and late term abortion; 6) The methodology of abortion throughout the gestational period; 7).Reasons cited for late term abortion; and 7) Anesthesia and analgesia for the unborn child during abortion.

Fetal development with respect to pain:

> The literature with respect to the development of the nervous system in the human unborn child addresses the topic from the perspective of the very preterm neonate as well as the intrauterine studies. According to Dr. Jean Wright's testimony to the U.S. House (1996) and Senate

(1998), studies provide insight into the development of the human unborn child in a variety of directions. First, clear indication that the anatomical and physiological (structural and functional) processes that mediate nociception (pain and noxious stimuli) are present in very preterm neonates. Furthermore, the density of nociceptive nerve endings in the late fetus and newborn infant are at least as dense as in the adult human (Wright, 1996).

Sensory perception (response to sensory stimulation) occurs in the unborn child by the 7th week of gestation around the mouth (Richeimer, 2000) and spreads to the entire skin and mucous surfaces by 20 weeks gestation (Wright, 1996). Experiments have demonstrated that this process of sensitivity progresses in the unborn child in the following manner. At just before 8 weeks gestation the unborn child will manifest a set of protective movements to avoid a mere hair stroke on the cheek. This sensitivity extends to the genital area at 10 weeks, the palms of the hands at 11 weeks and the soles of the feet by 12 weeks. By 17 weeks, the abdomen and buttocks are sensitive to this type of stimulation as well as to heat, cold, pressure and pain (Chamberlain, 2003). Additional investigations into the development of the unborn child demonstrate purposeful movement and exploration by the fetus at 10 weeks gestation (Tajani and Ianiruberto, 1990). By 14 weeks, the unborn child demonstrates a complete repertoire of movement including spontaneous, provoked and interactive types therein exploring itself and its environment (deVries, Visser, and Prechtl, 1985). The structures for taste develop at about 14 weeks gestation and the nose with its sensory

receptors develops between 11 and 15 weeks. New research indicates that the chemicals that cross the placenta barrier to mix in the amniotic fluid permit the unborn child a range of tastes and smells. This stimulates development of the neurological circuits. Schaal, Orguer, and Rogan (1995) cite evidence for direct and indirect learning of odors including dietary products ingested by the mother. This learning prepares the newborn to respond to various odors with no extrauterine experience for those odors.

Reactive listening begins at 16 weeks gestation – fully 8 weeks before the external ear has completely developed (Shahidullah and Hepper, 1992). Currently, it is not possible to assess vision in utero but premature babies from 28 to 34 weeks gestation are able to begin to focus and soon track visual stimuli in both vertical and horizontal directions (Chamberlain, 2003). With this evidence of the development of the neurological circuits for the unborn child in terms of touch (somatosensory), movement (vestibular), pain (nociception), smell (olfactory), taste (gustatory), sound (auditory) and possibly sight (visual), it becomes evident that the unborn child is a sensing being beginning at 7 weeks gestation and progressing to more integrated sensory experiences through 28 weeks gestation. At 20 weeks gestation, twins in utero have no trouble locating each other and touching each other's faces and holding hands (Chamberlain, 2003).

Touch develops first and includes pain sensation. The fetus, by the middle week of the gestational period feels touch and pain all over its body. The lack of myelination of the nociceptive neurological tracts does not negate the perception of pain. In fact, the nociceptive impulses in

adults can be carried in unmyelinated or thinly myelinated fibers. Additionally, the nerve tracts associated with nociception in the spinal cord (reflex pain fibers) and brain stem are completely myelinated up to the thalamus by 30 weeks gestation. The thalamus is the brain organ that integrates all sensory stimulation except smell and sends signals to the various parts of the cortex for processing. The unborn child's neocortex begins development at 8 weeks gestation and has a full complement of neurons by 20 weeks. The connecting components of cortical neurons (dendrites) proliferate and connections with the thalamus and other portions of the cortex occur. These connections occur between 20 and 24 weeks gestation (Anand, et.al., 1987). With this integration in mind, it is not surprising that EEG (brain wave) patterns in preterm babies of less than 28 weeks gestation are present with both visual and auditory evoked potentials demonstrating cortical components, and somatosensory (touch, pain, heat and cold) evoked potentials were measured at 26 weeks gestation (Wright, 1998). This means that these babies are processing touch, pain, temperature, sound and light by 26 to 28 weeks of gestation. Well defined periods of sleep and wakefulness are present in utero from 28 weeks forward (Wright, 1996).

Ultrasonic recordings of fetal responses to needle punctures in utero and intrauterine blood sampling reveal that unborn children between 20 and 24 weeks gestation demonstrate hormonal responses to pain consistent with fetal perception of pain and were correlated with duration of the painful stimuli (Wright, 1998). Within ten minutes of inserting a needle into an unborn child's hepatic artery for transfusion, the unborn child

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Historically, it was thought that the preterm infant had less sensitivity to pain than did the term neonate or adult human. Studies now reveal this to be false. Five key indicators have been used to demonstrate this pain perception. The first is the cutaneous flexor reflex. This is used to determine when the connection between the skin and the spinal cord are first made in the unborn child. This reflex has been shown to parallel pain perception in terms of threshold, peak intensity, and sensitivity to analgesics in adult humans. Thus, that the threshold is lower in the preterm neonate indicates that pain perception is more easily triggered than in the adult (Wright, 1996).

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Statistics of abortion and late term abortion: Statistics on abortion have been collected since 1969 by the Centers for Disease Control and since 1974 by The Alan Guttmacher Institute. The Centers for Disease Control and Prevention (CDC) collects abortion data to focus on the safety of the procedure and collects its data through reports from state health departments. These vary in completeness and are not available at all from Alaska, California, Iowa, New Hampshire, and Oklahoma. The information contained in these reports may be lacking on 40 to 50% of the abortions performed in the state. Limited surveys of abortion providers and general estimates are made for these states. Forty states report on the type of abortion procedure used and general demographic characteristics of women having abortions. The Alan Guttmacher Institute (AGI) concerns itself with the availability of abortion services throughout the United States. This data is collected via surveys of all known abortion providers, numbering 2,380 nationwide (Alan Guttmacher Institute, 1997). AGI is accepted as more accurate, recording all but those performed by physicians in their offices for their own patients. Reports by AGI average 15% higher than those reported by the CDC. Typically, surgical abortions are performed in hospitals or clinics. If this method becomes widely available in private physician's offices, underreporting is likely to increase (Alan Guttmacher Institute, 1997).

All of the reported numbers are at the low end of the actual number of abortions. Several factors are involved. First, abortions are under reported. Second, the data regarding late term abortions is incomplete, in part because the

number of physicians performing late term abortions is relatively few and those have large caseloads. Considering this, even one physician per geographic region not reporting would drastically skew the data. Labor may be induced for conditions other than elective abortions and the reports of fetal deaths that are removed from the mother via this methodology may be reported as abortions (Alan Guttmacher Institute, 1997). With all of these factors affecting the accuracy of the data, it is still important to examine the data as it has been reported over the thirty years since *Roe* v. *Wade* in order to gain an appreciation of the magnitude of the issues of fetal pain.

Given these reporting caveats, it is estimated from extrapolated figures from unpublished data compiled from 14 states reporting to the National Center for Health Statistics (NCHS) that the number of abortions performed after 26 weeks ranges from 320 to 600 annually. All of these abortions are performed after the age of viability. The CDC reports that approximately 1 to 1.5% of all abortions are performed after 20 weeks gestation. This translates to approximately 16,450 (1992) to 20,490 (1996) annually (The Alan Guttmacher Institute, 1997; CDC, 1996). The total number of abortions in 1992 was 1,528,930 (The Alan Guttmacher Institute, 1997) and 1,366,000 in 1996 (CDC, 1996). Since 1973, approximately 40,000,000 unborn children have been voluntarily terminated in the United States and approximately 480,000 have been after the 20th week of gestation. Remember, this number is probably very low because of the underreporting that occurs in most states. The CDC estimates that these numbers may represent from 50% to 60% of the actual abortions performed in

the United States (CDC, 1996). Teens are more likely than older women to delay abortion until late in the gestational term and approximately half of the women seeking late term abortion do so because of difficulties in affording, finding or getting services (CDC, Alan Guttmacher Institute, 1990; CDC, 2002).

The methodology of abortion throughout the gestational period:

The gestational period in the human is approximately 39 to 40 weeks from the beginning of the woman's last menstrual period. This gestational period is generally divided into trimesters with the first ending at the end of the 13th week, the second ending after week 24 and the third ending at the birth of the child. Abortion methodologies differ according to the gestational age of the unborn child. Early abortions are much easier to perform and are much safer for the mother (1 in 100,000 maternal deaths). The maternal death risks increase by 30% each week after 12 weeks gestation (Encarta, 2003).

During the first 72 hours after unprotected sex, a pill, commonly referred to as the "morning after pill", is taken by the mother and a second pill is taken 12 hours later. This inhibits ovulation or alters the lining of the uterus preventing implantation of a fertilized egg. Within the first seven weeks of pregnancy, abortion pills of RU-486 or mifepristone blocks the hormone progesterone. Progesterone is essential in maintaining the pregnancy. A second drug, misoprostol, is taken 48 hours later to induce uterine contractions to expel the fetus. A third drug may be taken in combination with misoprostol. That is the chemotherapy (anticancer) drug methotrexate.

This drug interferes with cell division and kills the fetus (Encarta, 2003).

Two surgical techniques are used during the first trimester: preemptive abortion and early uterine evacuation. In both methods, a narrow tube is inserted through the cervix into the uterus and attached to a suction devise like a syringe. The contents of the uterus are then sucked out. This includes the unborn child. The preemptive abortion uses a smaller cannula and is performed prior to the first four to six weeks while the early uterine evacuation uses a larger cannula and is performed from six to eight weeks. Both methods risk infection and bleeding (Encarta, 2003).

Vacuum aspiration requires that the cervix be dilated so a cannula can be inserted into the uterus. This occurs from the 6th week to the 14th week of gestation. Dilators of progressive sizes may be used to open the cervix enough to insert the larger cannula for the aspiration. Again, the contents and the lining of the uterus are sucked out (Encarta, 2003). Local anesthesia is all that is necessary for the mother. Dilation and curettage (D&C) is performed from the 6th to the 16th week and is similar to vacuum aspiration. The cervix is dilated and then the uterus is scraped to remove the contents. A D&C may require general anesthesia and must be performed in a clinic or hospital. The vacuum aspiration has nearly replaced the use of the D&C (Encarta, 2003). Abortion becomes much more difficult and risky after the 16th week. Dilation and Evacuation (D&E) requires greater dilation of the cervix than other methods. It also requires the use of suction, a large curette (scraping tool), and a grasping tool called forceps to remove the fetus. The suction

will frequently remove limbs from the unborn child prior to its death. This causes the unborn child extreme pain. The size of the fetus is a major issue as is the thinness of the uterine wall. Bleeding frequently occurs. This procedure is typically performed during the second trimester but may occur as late as 24 weeks (Encarta, 2003).

Induction abortion can also be performed during the second trimester. This requires that a small amount of amniotic fluid be removed and another chemical injected to replace it. This other chemical induces labor within the next one to two days. Heavy bleeding, infection and cervical injury are frequent. This requires hospitalization of one or more days (Encarta, 2003). The unborn child may be born alive then terminated or may die during the stress of the labor process. This child experiences pain in response to the chemical induction.

Abortions performed at the end of the second trimester and during the third trimester require major surgery. A hysterotomy is similar to a cesarean section with the abdomen cut open and the unborn child removed and terminated (Encarta, 2003). This is performed from 24 weeks gestation forward. With today's technology available in neonatal intensive care units, this unborn child would be viable (able to live).

The other procedure performed in late term (24 weeks forward) is the intact dilation and extraction or partial birth abortion. The techniques utilized in partial birth abortion include two components that cause considerable infliction of pain upon the unborn child of sufficient gestational age to perceive this pain. The first is the

extraction of the infant from the uterus through manipulation and compression and to drag the unborn child through the birth canal feet first so that only the head remains partially within the canal. The rest of the unborn child has been externalized and is delivered. This causes severe multiple painful stimuli. Second, an actual incision is made into the scalp tissues into the upper cervical canal and posterior fossa (opening) of the skull. As with any cut, pain occurs. Once the cut is made, a tube is inserted into the hole and the unborn child's brain is sucked out. This occurs in unborn children 24 weeks and slightly older. With current medical techniques, these children are viable. All of this is performed with no anesthesia to the unborn child. This is torture and is not tolerated in animal experimentation but is performed routinely to human beings. White concludes that "pain in the rat is ethically more reprehensible than pain in the human fetus" (White, 1995). Late term abortions are much riskier for the mother with 1 in 8,000 dying as a result of the procedure (Encarta, 2003).

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AFFIDAVIT

STATE OF TEXAS)
) **SS**
COUNTY OF)

I, the undersigned, do hereby certify that the following argument incorporates research on the scientific changes in medical knowledge in regard to fetal viability/humanity and fetal pain since the decisions of *Roe* and *Casey*. The abstract is written and edited by the Suzanne Besser, BS and Dr. Lucinda Harman, RN, MA, PhD, and attached in its entirety as an Appendix.

I have my Bachelors in General Studies and secondary teaching certification from the University of Mary Hardin-Baylor. My master's studies are in counseling. I began researching, writing and speaking on issues involving prenatal children in 1983. I have spoken to physicians and other professional organizations on these issues across the United States and introduced the issue of the prenatal child's ability to experience sensation including pain, to the State of Texas House Bill 15 "A Woman's Right to Know" brochure workgroup. My work prompted the group's inclusion of two statements, concerning sensation and pain, in their brochure.

Dr. Lucinda Harman has her Masters and PhD in Neuro Science from the University of Louisville. She is a registered nurse, has practiced neonatal intensive care nursing, and done research in neonatology.

As evidence of this Affidavit, I have hereunto set my hand this 1st day of February, 2005.

/s/ Suzanne Besser
Suzanne Besser

Subscribed and sworn to before me this 1st day of February, 2005.

/s/ Mary Ruth Miller
Notary Public

My Commission Expires:

[Seal] MARY RUTH MILLER
Notary Public, State of Texas
My Commission Expires
July 9, 2007

APPENDIX B

ABSTRACT

STATUTES:

Ala. Code 1996, § 30-3-152 (Silent)

Alaska Stat. § 25.24.150 (Silent)

Ariz. R.S. §§ 25-321. (Silent), 25-403

Ark Code Ann. §§ 6-71-138
Ark Code Ann. §§ 9-13-101

Cal. Pen. C. §§ 3040 to 3048 (Silent)
Cal. Pen. C. §§ 3010 to 3011

Colo. R.S.A. §§ 14-10-116
Colo. R.S.A. §§ 14-10-124

Conn. G.S.A. § 319-319J
Conn. G.S.A. § 802-803
Conn. G.S.A. § 813
Conn. G.S.A. § 815(j)(p)(t)(y)
Conn. G.S.A. § 895
Conn. G.S.A. § 967
Conn. G.S.A. § 882

Del. Code 72 § 9007(a)

Fla. S.A. 61 §§ 61.403
Fla. S.A. 61 §§ 61.13

Hawaii RS §§ 587-34
Hawaii RS §§ 587-24

Idaho C. §§ 10-1632

Ill. CS 5/602 S.H.A. 750
Ill. CS 405/2-17 S.H.A. 705

Iowa C.A. §§ 598.12
Iowa C.A. §§ 598.41

Kan. S.A. 38-1505
Kan. S.A 38-1559

Ky. R.S. 403.270
Ky. R.S. 620.027
Ky. R.S. 625.041

La. CHC 1269.4
La. CHC 675
La. CHC 710
La. CHC 1641
La. CHC 1632
La. CHC 1633
La. CHC 1637
La. CHC 1638

Me. R.S.A. 694 § 1653(b), (e)
Me. R.S.A. 55 § 1507

Md. Code §§ 5-525.1., 10-118

Mass. G.L.A. c. 208, §§ 31
Mass. G.L.A. c. 201, §§ 34

Mich. C.L.A. § 330.1723a
Mich. C.L.A. § 330.1616
Mich. C.L.A. § 722.27

Minn. S.A. § 257.0762 (Silent)
Minn. S.A. § 259.65
Minn. S.A. § 259.20
Minn. S.A. § 260C.301

Miss. Code § 43-15-13
Miss. Code § 43-21-311
Miss. Code § 93-5-23
Miss. Code § 9-5-89
Miss. Code § 43-21-121
Miss. Code § 93-5-9

Mo. V.A.M.S. § 452.423 (Silent)
Mo. V.A.M.S. § 453.025
Mo. V.A.M.S. § 210.160
Mo. V.A.M.S. § 211.462
Mo. V.A.M.S. § 507.200
Mo. V.A.M.S. § 452.402

Mont. CA § 40-4-205, 40-4-212

Neb. R.R.S. § 43-533, 42-364, 43-292.01, 43.163

Nev. R.S. §125C.010, 65.0107
N.H. RSA §458:17-a
N.H. RSA § 169-C:10

N.J.S.A. 2A:4A-39

N.M.S.A. § 32A-1-7
N.M.S.A. § 40-4-9.1

N.Y. Penal Law § 14-5-70 to 14-5-73
N.Y. Penal Law § 14-6-80

N.C.G.S. § 35A-1107
N.C.G.S. § 50A-25

N.D.C.C. § 14-09-06.1
N.D.C.C. § 14-09-06.2
N.D.C.C. § 14-09-06.4

Ohio R.C. § 3109.04

Okl. St.Ann. § 10-1415
Okl. St.Ann. § 10-7003-3.7
Okl. St.Ann. § 10-7505-1.2
Okl. St.Ann. § 43-109

Ore. RS § 107.27(a)

Pa. Stat. 246/800 § 806
Pa. Stat. 246/800 § 805

S.C. Code § 20-7-85
S.C. Code § 20-7-110
S.C. Code § 20-7-121
S.C. Code § 20-7-124
S.D.C.L. § 26-7A-18
S.D.C.L. § 26-7A-5
S.D.C.L. § 25-6-2
S.D.C.L. § 25-5A-15
S.D.C.L. § 26-7A
S.D.C.L. § 25-6
S.D.C.L. § 25-5A
S.D.C.L. § 0.7742
S.D.C.L. § 15-6-17(c)
S.D.C.L. § 29A-5-117
S.D.C.L. § 15-39-77

Tenn.C.A. § 29-29-103
Tenn.C.A. § 36-6-101

Tex. Ann. C.Cr.P. § 153.001
Tex. Ann. C.Cr.P. § 107.000(a)

Utah Code § 30-3-10
Utah Code § 75-7-305

Va. Code § 8.01-73
Va. Code § 21-310
Va. Code § 20-146.12
Va. Code § 16.1-278.15

Wash. Rev. Code § 26.10.070
Wash. Rev. Code § 26.10.100

W.Va. Code § 56-4-10
W.Va. Code § 36-2-5

Wis. S.A. § 48.01(1)(gr)
Wis. S.A. § 20.625(1)(e)

B5

Wyo. Stat.1983 § 14-7-101 to 14-7-104
Wyo. Stat.§ 20-2-201

AFFIDAVIT

STATE OF MISSOURI)
) SS
COUNTY OF BOONE)

I, the undersigned, do hereby certify that the following, Abstract B incorporates statutes on the Best Interest of the Child standard and use of Guardians Ad Litem. The abstract is researched and prepared by Heather Brinkley, and attached in its entirety as an Appendix.

I have my Associate of Science Degree in Legal Studies with an emphasis in Legal Assistant from Missouri Western State College.

As evidence of this Affidavit, I have hereunto set my hand this 3 day of February, 2005.

/s/ Heather Brinkley
Heather Brinkley

Subscribed and sworn to before me this 3rd day of February, 2005.

/s/ Elizabeth E. Parrigin
Notary Public

My Commission Expires:

ELIZABETH E. PARRIGIN
Notary Public – Notary Seal
State of Missouri
Boone County
My Commission Expires
May 22, 2006